and physician, vis-à-vis the other, rather than on the human bond that encompasses both. But in the profession's flight from paternalism, the implications of this caring bond, in formal discourse blandly spoken of as the physician-patient relationship, seem to be overlooked in most of the current ethical analyses.

Caring need not be paternalistic, as seen in the way we care for a friend, a respected colleague, or even an admired teacher. With each, we might take an action that overrode their expressed wishes simply because we cared enough to risk the relationship or, in the case of a patient, a lawsuit. There is a difference between beneficence, which entails action in an impersonal spirit of kindness, and caring, where a personal involvement is the crucial determinant of action. As proponents of scientific medicine, have we become so fearful of the personal and subjective that we are unable to recognize this distinction? Do we fear to acknowledge caring because of the personal involvement it might imply? Because of the responsibility it might imply? Must we cite Ingelfinger's argument for a beneficent arrogance (from a paper that can be read in an entirely different manner)[3] to justify an occasional lapse into caring behavior?

Dr Orr's actions reveal him to be a caring physician. His ruminations are a sad commentary on how far we still have to go in understanding Peabody's message.

SIMON AUSTER, MD, JD
Family Practice and Psychiatry
Uniformed Services of the Health Sciences
F. Edward Hebert School of Medicine
Bethesda, MD 20814-4799

The opinions or assertions contained herein are the private views of the author and should not be construed as official or as necessarily reflecting the views of the Uniformed Services University of the Health Sciences or the US Department of Defense. There is no objection to its presentation and/or publication.

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2. Peabody FW: The care of the patient. JAMA 1927; 88:877
3. Ingelfinger FJ: Arrogance. N Engl J Med 1980; 303:1507-1511

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To the Editor: The "Lesson From the Practice" by Robert D. Orr, MD,[1] and Mrs Pulaski's situation brought back lessons learned during a three-hour seminar on ethical dilemmas given during the American College of Healthcare Executives Congress in Chicago last month.

We were divided into groups of about eight, and each group considered a different case study. Mine considered the case of an 82-year-old woman whose family wanted to avoid having a pneumoencephalography (PEG) line surgically inserted into her stomach. Despite a few statements to the contrary, the group voted almost unanimously to appeal to the family to permit the surgical procedure; failing that, the hospital would go to court to gain guardianship of the woman, then do the procedure and send her to a nursing home. When these results were offered to all the seminar participants (made up of hospital executives and some clinical people), no one voiced strong objections, and the hospital's need to protect itself from legal liability was again reiterated. A number of comments were made about the irrelevancy of the family's wishes. The hospital's position was likened to "abetting suicide" if it did not insist on the surgery.

I later learned that the actual patient of this case study did get the PEG line—the physician and staff appealed to a son who eventually gave in—and was sent to a nursing home, where she died three months later. When I asked the seminar leader, who knew the woman and her family, if she valued those last three months, he said "No."

I suspect that 93-year-old Mrs Pulaski, by refusing hospital admission, hoped to avoid losing control of her future. She had reason to be concerned.

SUSAN J. ANTHONY
Editor, Healthcare Forum Journal
425 Market St, 16th Floor
San Francisco, CA 94105

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Dr Orr Responds

To the Editor: Dr Howitt deduces that Mrs Pulaski lacked decision-making capacity and did not appreciate the gravity of the situation. She may well be correct, but my concern, in retrospect, was that I had not adequately assessed her decision-making capacity and had overruled the paramedics' attempts to inform her. Although the ability to give informed consent may be impaired by illness, denial, and other factors, we must take care that we do not revert to the old standard that determined patients to be incompetent if they did not agree with their physician.

I hope that Dr Auster is correct in his implication that Dr Peabody would have interpreted my "paternalistic" action as caring. The "casuistic catechism of contemporary ethical analysis" is not, however, to be completely ignored. Although I might have chosen a different word than arrogance (per Dr Ingelfinger) to characterize a physician's responsibility to make a recommendation, caring (good) can truly become arrogant (bad) in some situations. The caring human bond that Dr Auster describes is probably more operative in an established physician-patient relationship than in a medical crisis confronted by strangers. I am relieved to have my actions perceived as caring rather than arrogant, but disappointed that he found my ruminations to be a sad commentary on medicine and medical ethics.

Ms Anthony's brief case report allows me the opportunity to tell readers that "Mrs Pulaski" had a brief stay in the hospital, a few weeks in a convalescent home, and 18 months ago returned home with a live-in companion. She appears to be glad for my paternalistic intervention, although I have not had the opportunity (nor the courage) to ask her directly.

ROBERT D. ORR, MD
Department of Family Medicine
Loma Linda University Medical Center
Loma Linda, CA 92354